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FIG. 1 - HOME SCREEN 1

VoxDox4 Clinical Command Center: Physician Office -- Dr. John Gordon

TOOLS Data Manager Review Fax Log Configure About GO Home Exit Log Off

SELECT Patient New Held Template DOCUMENT Edit Create Clear

Recipient
No Recipient for Document Type

John Gordon

- 1 - H&P AMA
- 2 - H&P Female
- 3 - H&P Male
- 4 - Progress Note
- 5 - Replicate Abridged
- 6 - Replicate Complete
- 7 - SOAP CV
- 8 - SOAP Diabetes
- 9 - SOAP ENT/Mouth
- 10 - SOAP Eyes
- 11 - SOAP Generic
- 12 - SOAP GU Female
- 13 - SOAP GU Male
- 14 - SOAP Hem Lymph Immun
- 15 - SOAP Musculoskeletal
- 16 - SOAP Neurological
- 17 - SOAP Psychiatric
- 18 - SOAP Respiratory
- 19 - SOAP Skin
- 20 - Urological

Patient Name: Brown, James
ID: 000019 Gender: male
Date of Birth: 5/15/1948 Age: 54

Chief Complaints:
10/4/2001 - New Patient Problem

Current Assessments/Diagnosis:
Assessment - No Data

Meds Current
1.

Allergy Hx Summary
1.

Medical Hx Summary
1.

PLAN
1.

Document Type:

- History
- Nursing Note
- Order
- Order Progress Note
- Patient Instruction
- Patient Letter
- Picture Note
- Prescription
- Procedure Note
- Referral Letter
- SOAP Note

Home SOAP CV

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FIG. 2 - HOME SCREEN 2

VoxDox4 Clinical Command Center: Physician Office -- Dr. John Gordon

TOOLS Data Manager Review Fax Log Configure About GO Home Back Exit Log Off

VIEW Edit Only Documents Inserts Summary PLAYBACK Start Stop SENTENCE Previous Current Next ITEM Previous Next

DOCUMENT Verify Sign Hold Delete Backups LINK Create Delete

Times New Roman 11 B I U

Patient Name: Brown, James J ID: 000010
 Gender: Male Date of Birth: 5/15/1948 Age: 54
 Exam Date: 11/19/2003

SUBJECTIVE
 Chief Complaint: patient's reason for visit.
 HPI: James is a 54 year old Caucasian male who reports state reason.
 Patient says that he feels well. Does not feel well. []
 Chronic Dz
 1.

Medications:
 Meds Current
 1.

SHOW Medication
 Med Side Effects: none reported.

Symptom Review
 Shortness of breath: denies.
 Chest pain: denies.
 Dizziness: patient reports that the condition began onset. Onset was associated with activity.
 Quality: patient describes description.
 Severity: he describes description.
 Modifying factors: condition is worsened by aggravating factors. Condition is lessened by alleviating factors.
 Associated signs/symptoms: describe.
 Timing: patient reports that timing.
 Location: patient reports that location.
 Context: context.

Associated Cardiac Symptoms:
 Difficulty breathing on exertion: denies.
 Fatigue on exertion: denies.
 Rapid or irregular heartbeat: denies.
 Swelling of legs: denies.
 Other: describe.

Page 1 Line 3 Col 72 100% NUM
 Edr Brown - SOAP CV

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FIG. 3 - EDIT SCREEN 1

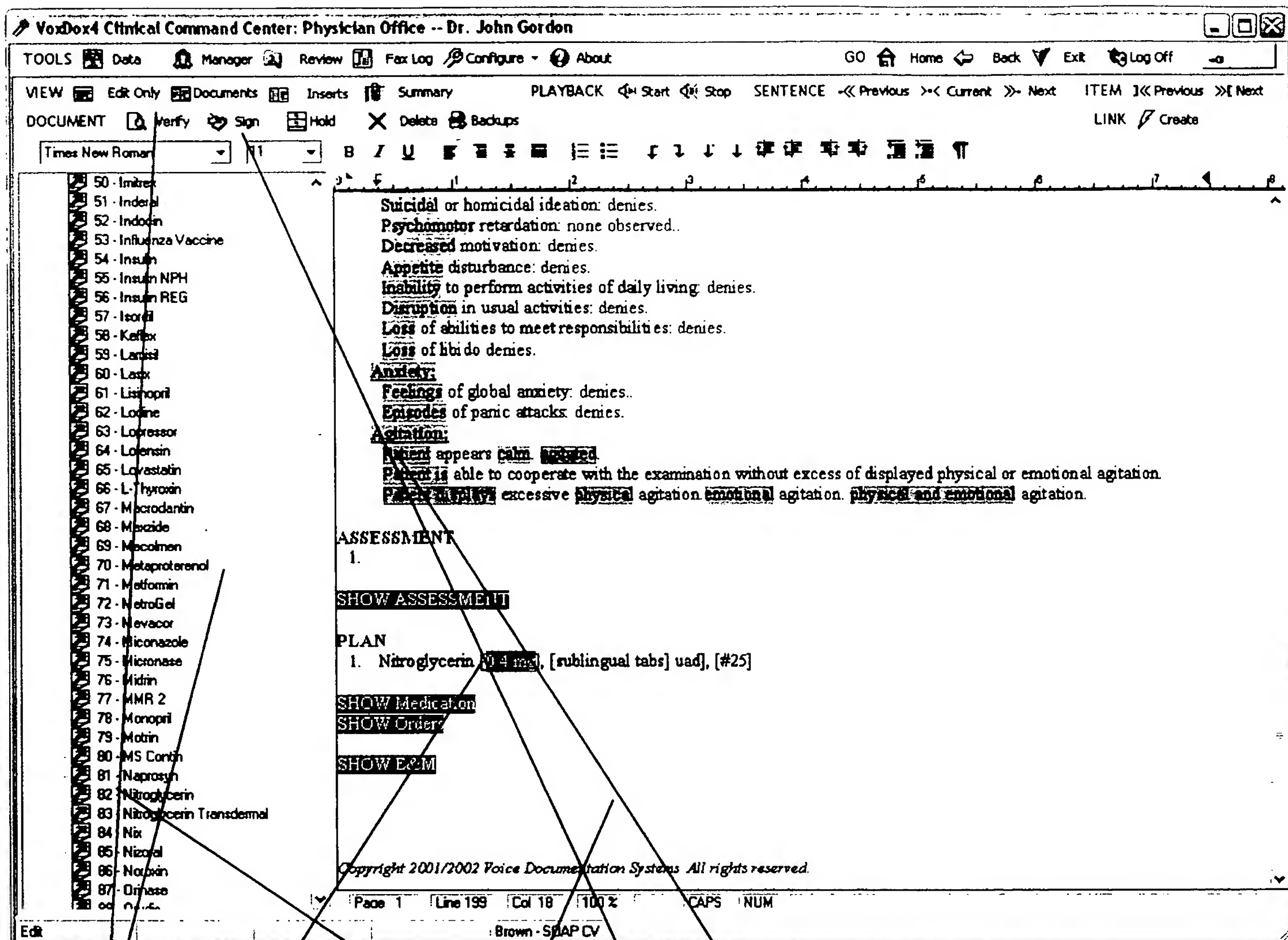


FIG. 4 - EDIT SCREEN 2

VoxDox4 Clinical Command Center: Physician Office -- Dr. John Gordon

TOOLS Data Manager Review Fax Log Configure About

GO Home Back Exit Log Off

DOCUMENT Sign Hold Spawn Print Fax Delete Spell

VIEW Summary Documents Outline

James Brown

Current Document: SOAP CV

SOAP Note

Test - 6/27/2002

New Patient H & P - 10/4/2001

Next: Script

Masses & Tenderness: abdomen is flat, soft, non-tender. No masses. Bowel sounds: +. No rebound or guarding. No surgical scars.

Organomegaly: none.

Musculoskeletal Exam: Normal symmetry. No signs of focal weakness or atrophy.

Gait & Station

Station: patient demonstrates normal posture.

Gait: patient exhibits a normal smooth, stable and balanced gait.

*Posture and movement during gait and at rest: Muscle Strength & Tone: normal.

Extremities: inspection and palpation of digits and nails: clubbing: none; cyanosis: none; inflammation: none; petechiae: none; ischemia: none; infections: none; Osler's nodes: none.

Skin Exam

Inspection of skin shows it to be warm and dry. Color: normal. No changes of chronic venous stasis. There are no stasis ulcers.

Palpation of skin & subcutaneous tissue shows: turgor: normal; edema: none.

Psychiatric Exam

Orientation to time, place and person is appropriate.

Mood & Affect

Depression: Mood and affect: normal. Suicidal or homicidal ideation: denies. Psychomotor retardation: none observed. Decreased motivation: denies. Appetite disturbance: denies. Inability to perform activities of daily living: denies. Disruption in usual activities: denies. Loss of abilities to meet responsibilities: denies. Loss of libido: denies.

Anxiety: Feelings of global anxiety: denies. Episodes of panic attacks: denies.

Agitation: Patient appears calm. Patient is able to cooperate with the examination without excess of displayed physical or emotional agitation.

ASSESSMENT

1.

PLAN

1. Nitroglycerin 0.4 mg, sublingual tabs used, #25

John Gordon, M.D.

Wednesday, September 04, 2002 16:41

Spawns:

Type	Title	Recipient	Signed
Script	Script	None	No

Attachments:

Type	Title	Signed

Verify

Brown - SOAP CV

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FIG. 5 – VERIFY SCREEN

VoxDox4 Clinical Command Center: Physician Office -- Dr. John Gordon

TOOLS Data Manager Review Fax Log Configure About

GO Home Back Exit Log Off

VIEW Edit Only Documents Inserts Summary

PLAYBACK Start Stop SENTENCE Previous Current Next ITEM Previous Next

DOCUMENT Verify Sign Hold Delete Backups

LINK Create

Times New Roman 9

John Gordon, M.D.
 2222 Your Street
 Your City, CA 95401
 Phone: (555) 555-1234 Fax: (555) 555-1235
 License: 123123 DEA: 123123

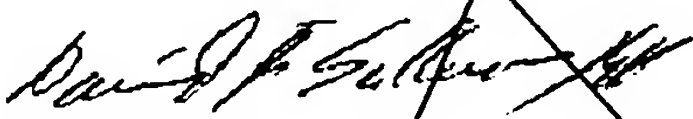
R_x

Date: Wednesday, September 04, 2002

Patient: Mr. James Brown
 Patient Home Phone: (530) 588-7463

Rx:
 Nitroglycerin 0.4 mg, sublingual tabs uod, #25

Use generic when available.
 Do not fill until ready.
 Patient on wait, please fill immediately.
 Please fill when prescription is ready.



John Gordon, M.D.

Page 1 Line 14 Col 46 100% CAPS NUM

Edit Brown - Script

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FIG. 6 – GENERATED PRESCRIPTION IN EDIT SCREEN

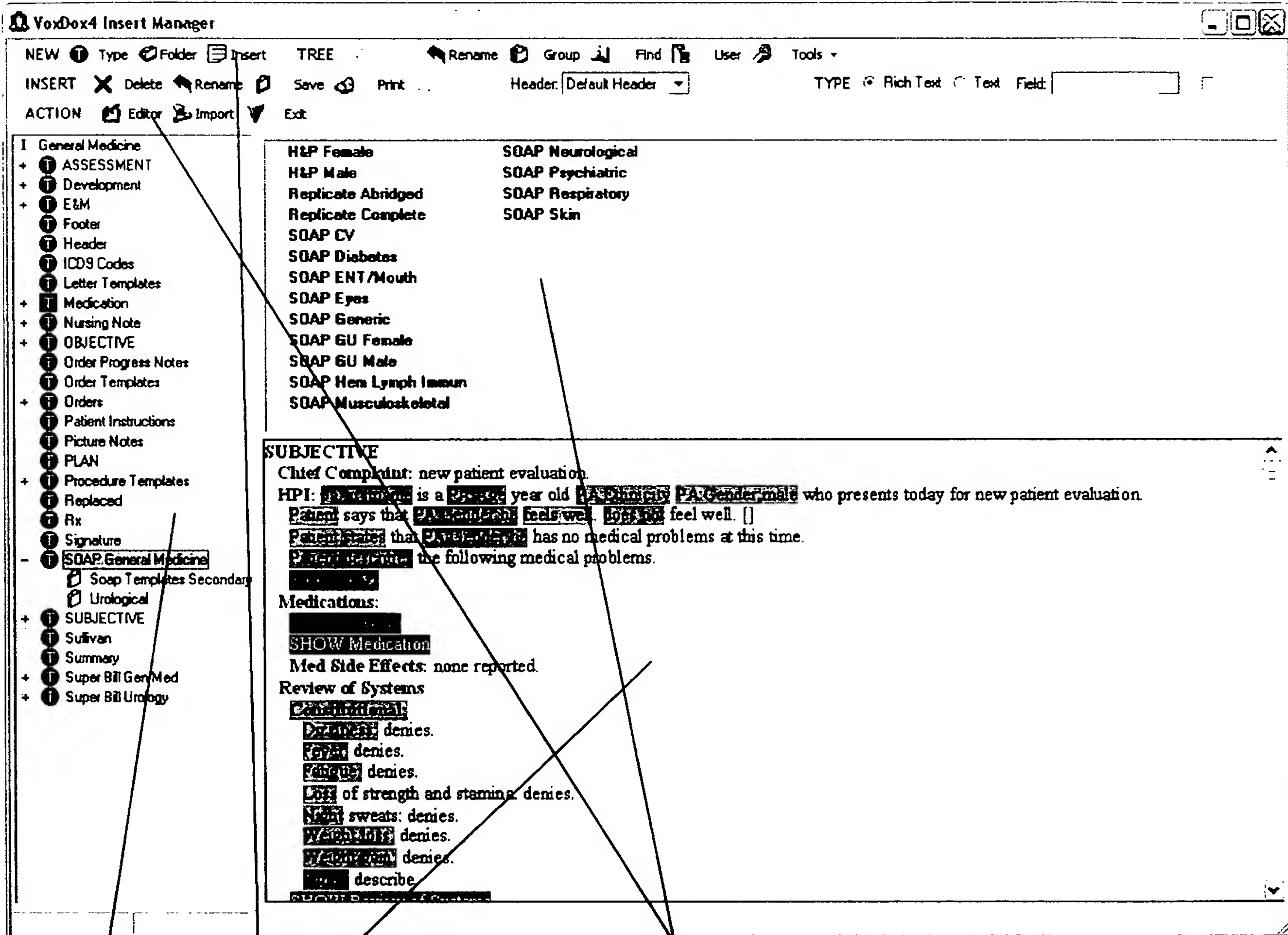


FIG. 7 – INSERT MANAGER

Document Types

Document Types:

- History**
- Nursing Note
- Order
- Order Progress Note
- Patient Instruction
- Patient Letter
- Picture Note
- Prescription
- Procedure Note
- Referral Letter
- SOAP Note

General	Inserts	Print Info
Name:	Key:	<input checked="" type="checkbox"/> Use as Data Source
History	HX	<input type="checkbox"/> Default Type
Header:		<input type="checkbox"/> No Editing
examHeader		<input type="checkbox"/> No Verify
Footer:		<input type="checkbox"/> Needs Recipient
(None)		<input type="checkbox"/> Recipient to Multiple
Signature:		
Default Signature		
<input type="checkbox"/> Export To:		
		Browse...
Default Link Folder:		
		Browse...

Delete Type New Type Done

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FIG 9 – DOCUMENT TYPE CONFIGURATION